



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

ELITE HEALTHCARE FORT WORTH

**Respondent Name**

TEXAS DEPARTMENT OF TRANSPORTATION

**MFDR Tracking Number**

M4-19-4469-01

**Carrier's Austin Representative**

Box Number 32

**MFDR Date Received**

June 11, 2019

**Response Submitted By**

Stone Loughlin Swanson

#### REQUESTOR'S POSITION SUMMARY

"CARRIER IS TO PAY 80% PAYMENT FOR SERVICES FURNISHED. CARRIER ONLY PAID 43% ON THIS DATE OF SERVICE."

#### RESPONDENT'S POSITION SUMMARY

"Respondent paid the appropriate amount under Medicare payment policies for physical therapy codes"

#### SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 28, 2018	Physical Therapy Services	\$215.20	\$0.00

#### AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED.
  - 163 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR MULTIPLE PROCEDURE RULES.
  - 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES.
  - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
  - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
  - 1014 - THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.

**Issues**

Did the requestor waive the right to medical fee dispute resolution?

**Findings**

28 Texas Administrative Code §133.307(c)(1) requires that a requestor shall timely file the request with the division's MFDR Section or waive the right to medical fee dispute resolution (MFDR).

Rule §133.307(c)(1)(A) further requires that a request for MFDR that does not meet any exceptions listed in Rule §133.307(c)(1)(B) be filed no later than one year after the dates of service in dispute.

The disputed date of service is March 28, 2018.

The request was received in the division's MFDR Section on June 11, 2019.

This date is later than one year after the date of service in dispute. Review of the submitted documentation finds the disputed services do not involve issues identified in Rule §133.307(c)(1)(B). The division thus concludes the requestor failed to timely file this dispute with the division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

**Conclusion**

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

***ORDER***

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

	Grayson Richardson	July 3, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307. The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.